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March 14, 2008

Ms. Pat Van Buren, Program Manager
Department of Health
Health Regulation Administration, Long Term Care
825 North Capitol Street, NE
Second Floor
Washington. D.C. 20001

Dear Ms. Van Buren:

Enclosed you will find the National Children's Center's corrected application for the investigation of an accident that occurred on January 19, 2008. If you have any questions please do not hesitate to contact me.

Sincerely,

Ambus Harper

Ambus H. Harper, Jr. M.S.
Program Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G002	A. BUILDING _____ B. WING _____	C 02/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCC	6200 2ND STREET, NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS On January 23, 2008, the Health Regulation Administration (HRA), or State agency, received four incident reports via fax transmittal that were all related to the same incident. According to the reports, one staff and four clients of the above-listed Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) were involved in a "hit and run" vehicular accident on the evening of Saturday, January 19, 2008. Upon return to the facility, one of the four clients complained of neck pain and was subsequently taken to a hospital emergency room for evaluation. On February 5, 2008, telephone interview with the facility's Incident Management Coordinator revealed that several days after the vehicular accident, the client who had complained of neck pain, informed staff that the accident had occurred while one of the other clients had been driving. Since then, two other clients admitted that they had driven the vehicle. All four client admitted that the staff person had asked them to corroborate her account. The staff person had been placed on unpaid administrative leave. On February 6, 2008, the Incident Management Coordinator faxed to the State agency the facility's internal investigation report, dated February 4, 2008, in which the facility determined that a direct support staff person had allowed two clients to drive a facility vehicle. On February 8, 2008, HRA initiated an onsite investigation to determine compliance with federal and local standards of care with respect to prescribed staffing ratios and ensuring client safety while being transported in the community.	W 000	See Response to W104.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rendus Harper | Program Manager | 3/14/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficiant protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 000	Continued From page 1 The findings and conclusions in this report were determined through interviews and record review at the facility on February 8, 2008.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body provided general operating direction over the facility, except for the following: The findings include: On February 7, 2008, review of the facility's internal investigation report, dated February 4, 2008 revealed that they had determined that on January 19, 2008, a direct staff driver had allowed clients to drive the facility vehicle, made a false statement on the incident report form and to the police, and attempted to influence clients to collaborate on the false statement. The facility's Incident Review Committee documented a February 5, 2008 review of the incident and investigation, at which time the committee affirmed the internal investigation findings and conclusions. However, in addition to the self-identified deficiencies, the February 8, 2008 investigation revealed that 21 days after the accident, and 4 days after the internal investigation was completed, there was no evidence that the governing body sought to determine whether all relevant components of the facility's transportation policies were implemented at the	W 104		

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W 104	Continued From page 2 time of the January 19, 2008 accident, as follows: 1. On February 8, 2008, beginning at 10:08 AM, review of the facility's Transportation Policy, dated September 2006, revealed that whenever there was an accident involving clients, the direct staff driver involved in the accident should receive a drug screening within 24 hours of the accident. The accident happened on Saturday, January 19, 2008. The staff driver worked on Sunday, January 20, 2008 and again on Tuesday, January 22, 2008. It was reported that she had a drug screening performed on Wednesday, January 23, 2008, more than three (3) days after the accident was first reported. It should be noted that February 8, 2008 interviews with several managers and quality assurance staff revealed that they were unfamiliar with that aspect of the policies; they all stated that staff could wait until the lab opened on a weekday. 2. On February 8, 2008, further review of the facility's transportation policies revealed the following: "Responsibilities for assuring the safety and supervision of the individuals by the Direct Service or Program Staff Drivers includes: Knowledge of the Individual Plans of the individuals being transported which specifies the required ratio of staff to individual necessary to provide adequate supervision. For example, if the ratio stated is 1:3, this means there must be 1 staff for every 3 individuals ... If a fourth individual joins the group, a second staff member must be present ... It is the responsibility of the Program to assure that the Direct Service and Program Staff Drivers implement these rules and guidelines." At approximately 12:10 PM review of the four clients' Individual Support Plans (ISPs) revealed	W 104	1. The staff members that responded indicated that they were unfamiliar with this aspect of the policy, then the Agency will reinforce the transportation policy with the staff and the managers by 3/31/08. Any staff member who gains authorization to drive an Agency vehicle must review the transportation policy. All managers also are made aware of the Agency's transportation policy. This particular incident occurred on a Saturday night (a weekend preceding a Monday holiday MLK holiday). It is likely that the staff members who responded considered the time the incident occurred (a weekend night) and having the knowledge that the upcoming Monday was a holiday, the staff knew that the employee could not obtain testing before the laboratory reopened on a weekday after the holiday. The Agency's Human Resources Department is exploring with Labs to determine whether there are vendors who can provide services 24 hours/seven days per week. If there are no vendors that will accommodate the Agency, then the Agency will modify its policy to reflect a specified time period. For example, the policy might say .....and staff tested within 24 hours of accident or the next business day if accident is on the weekend or holiday. If the policy must be modified this will occur by 04/15/08 2. The staffing ratios are considered in every activity that is planned. In this instance the staff involved in the	03/31/08 03/31/08

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W 104	Continued From page 3 that Clients #2, #3 and #4 were prescribed 2:4 staff-to-client ratio between 7 AM - 10 PM and while on community outings (Client #1 had a 2:8 ratio prescribed). The facility's internal investigation had determined that there was one staff with four clients. At 12:22 PM, telephone interview with the evening shift supervisor revealed that a direct support staff person reportedly informed him that his co-worker (the staff person who was involved in the accident) was out in the community with four clients. Neither the direct support staff nor the supervisor took action (i.e. telephoned the staff driver by cell phone, etc.) after determining that she was alone in the vehicle with four clients. February 8, 2008 interviews with the Program Manager, Compliance Specialist and Incident Management Coordinator, as well as review of the internal investigation report, revealed that staff-to-client ratios had not been discussed or evaluated at the time of the accident, or since then. At 12:34 PM, the Program Manager acknowledged that he was previously unaware that the direct support staff and/or the shift supervisor on duty had expressed concern about the staffing ratio at the time of the accident, or that prescribed staffing ratios had not been implemented. The facility's Incident Review Committee (IRC) documented a February 5, 2008 review of the incident and internal investigation. Review of the IRC's findings and recommendations revealed no evidence that management sought to determine compliance with prescribed staff-to-client ratios and/or post-accident drug screening.	W 104	accident did not follow the supervisor's instruction and the staff that remained at the facility accepted their colleague's suggestion without checking the validity and soundness of it with their supervisor. Therefore, the supervisor was not notified that the employee was leaving to do an activity alone without the assistance of a co-worker. The Agency has officially terminated the employment of the individual involved in the accident as of 2/06/08. The Agency will continue to reinforce each staff member regarding their responsibility/obligation of reporting to their supervisor any situation that might be a potential safety hazard (including staffing patterns) as well as actions contrary to directions/instructions given by a supervisor or actions inconsistent with the Agency's policies. This will be reiterated continuously but the next official occurrence will be at the staff meeting held on 3/19/08. In addition the agency will review the staff ratios for three of the individuals involved by 3/31/08. It is indicated in an earlier answer that the client staff ratios will be reviewed. The findings of the Incident Review Committee's (IRC) review supported the investigators report that the employee provided false statements to the supervisor and on the incident reports. The post accident drug screening was set to occur on the first available date that the lab was to be open and the employee never returned to work. The policy might need to be modified so that it accommodates the weekends and holidays, times when traditional businesses that would do drug screenings are closed.	02/06/08 03/31/08

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I 000	INITIAL COMMENTS On January 23, 2008, the Health Regulation Administration (HRA) received four incident reports via fax transmittal that were all related to the same incident. According to the reports, one staff and four residents of the above-listed Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) were involved in a "hit and run" vehicular accident on the evening of Saturday, January 19, 2008. Upon return to the facility, one of the four residents complained of neck pain and was subsequently taken to a hospital emergency room for evaluation. On February 5, 2008, telephone interview with the facility's Incident Management Coordinator revealed that several days after the vehicular accident, the resident who had complained of neck pain, informed staff that the accident had occurred while one of the other residents had been driving. Since then, two other residents admitted that they had driven the vehicle. All four residents admitted that the staff person had asked them to corroborate her account of a hit and run. The staff person had been placed on unpaid administrative leave. On February 6, 2008, the Incident Management Coordinator faxed to HRA the facility's internal investigation report, dated February 4, 2008, in which the facility determined that a direct support staff person had allowed two residents to drive a facility vehicle. On February 8, 2008, HRA initiated an onsite investigation to determine compliance with federal and local standards of care with respect to prescribed staffing ratios and ensuring resident safety while being transported in the community. The findings and conclusions in this report were	I 000		

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I 000	Continued From page 1 determined through interviews and record review at the facility on February 8, 2008.	I 000		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the residents' right to safe travel in the community and right to receive staff supervision at the levels prescribed in his/her Individual Support Plan. The findings include: 1. Residential program staff and supervisors failed to ensure that prescribed staff-to-resident ratios were implemented, in accordance with the residents' annual plans. On February 8, 2008, beginning at 10:08 AM, review of the facility's Transportation Policies, dated September 2006, revealed the following: "Responsibilities for assuring the safety and supervision of the individuals by the Direct Service or Program Staff Drivers includes: Knowledge of the Individual Plans of the individuals being transported which specifies the required ratio of staff to individual necessary to provide adequate supervision. For example, if the ratio stated is 1:3, this means there must be 1 staff for every 3 individuals ... If a fourth individual joins the group, a second staff member must be present ... It is the responsibility of the Program to	I 500	1. If the staff members that responded indicated that they were unfamiliar with this aspect of the policy, then the Agency will reinforce the transportation policy with the staff and the managers by 3/31/08. Any staff member who gains authorization to drive an Agency vehicle must review the transportation policy. All managers also are made aware of the Agency's transportation policy. This particular incident occurred on a Saturday night (a weekend preceding a Monday holiday MLK holiday). It is likely that the staff members who responded considered the time the incident occurred (a weekend night) and having the knowledge that the upcoming Monday was a holiday, the staff knew that the employee could not obtain testing before the laboratory reopened on a weekday after the holiday. The Agency's Human Resources Department is exploring with Labs to determine whether there are vendors who can provide services 24 hours/seven days per week. If there are no vendors that will accommodate the Agency, then the Agency will modify its policy to reflect a specified time period. For example, the policy might say .....and staff tested within 24 hours of accident or the next business day if accident is on the weekend or holiday. If the policy must be modified this will occur by 04/15/08.	03/31/08 04/15/08

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I 500	Continued From page 2 assure that the Direct Service and Program Staff Drivers implement these rules and guidelines." At approximately 12:10 PM review of the four residents' Individual Support Plans (ISPs) revealed that Residents #2, #3 and #4 were prescribed 2:4 staff-to-resident ratio between 7 AM - 10 PM and while on community outings (Resident #1 had a 2:8 ratio prescribed). The facility's internal investigation had determined that there was one staff with four residents. At 12:22 PM, telephone interview with the evening shift supervisor revealed that a direct support staff person reportedly informed him that his co-worker (the staff person who was involved in the accident) was out in the community with four residents. Neither the direct support staff nor the supervisor took action (i.e. telephoned the staff driver by cell phone, etc.) after determining that she was alone in the vehicle with four residents. February 8, 2008 interviews with the Program Manager, Compliance Specialist and Incident Management Coordinator, as well as review of the internal investigation report, revealed that staff-to-resident ratios had not been discussed or evaluated at the time of the accident, or since then. At 12:34 PM, the Program Manager acknowledged that he was previously unaware that the direct support staff and/or the shift supervisor on duty had expressed concern about the staffing ratio at the time of the accident, or that prescribed staffing ratios had not been implemented. 2. The facility failed to ensure that the direct staff driver involved in the accident received a drug screening within 24 hours of the accident, in accordance with their Transportation Policy. On February 8, 2008, beginning at 10:08 AM,	I 500	2. The staffing ratios are considered in every activity that is planned. In this instance the staff involved in the accident did not follow the supervisor's instruction and the staff that remained at the facility accepted their colleague's suggestion without checking the validity and soundness of it with their supervisor. Therefore, the supervisor was not notified that the employee was leaving to do an activity alone without the assistance of a co-worker. The Agency has officially terminated the employment of the individual involved in the accident as of 2/06/08. The Agency will continue to reinforce each staff member regarding their responsibility/obligation of reporting to their supervisor any situation that might be a potential safety hazard (including staffing patterns) as well as actions contrary to directions/instructions given by a supervisor or actions inconsistent with the Agency's policies. This will be reiterated continuously but the next official occurrence will be at the staff meeting held on 3/19/08. In addition the agency will review the staff ratios for three of the individuals involved by 3/31/08.	02/06/08 03/19/08 03/31/08

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I 500	Continued From page 3 review of the facility's Transportation Policy, dated September 2006, revealed that whenever there was an accident involving residents, the direct staff driver involved in the accident should receive a drug screening within 24 hours of the accident. The incident happened on Saturday, January 19, 2008. The staff driver worked on Sunday, January 20, 2008 and again on Tuesday, January 22, 2008. It was reported that she had a drug screening performed on Wednesday, January 23, 2008, more than three (3) days after the accident was first reported. It should be noted that February 8, 2008 interviews with several managers and quality assurance staff revealed that they were unfamiliar with that aspect of the policies; they all stated that staff could wait until the lab opened on a weekday. 3. Other safety-related aspects of the facility's Transportation Policies were not implemented at the time of the January 19, 2008 incident, or afterwards, as follows: a. On February 8, 2008, both the Incident Management Coordinator and the Quality Improvement Specialist stated that the staff driver failed to telephone police from the accident scene and remain at the scene until police arrived. She also failed to telephone her supervisor. Review of the facility's Transportation Policy, dated September 2006, confirmed that this was facility policy. The facility's internal investigation report, however, did not reflect this deficient practice. Further interviews revealed that the direct staff driver had worked in the facility on Sunday, January 20, 2008 and again on Tuesday, January 22, 2008 without receiving any form of reprimand or disciplinary action for failing to remain at the scene.	I 500	3. a. The Agency's investigation was based upon what the staff member reported to the Supervisor on the night of the accident. At that point there was nothing to suggest that the event did not happen as reported. The staff member reported that the vehicle she was in was hit by another driver who sped off and left the seen. This situation would have put her in an unknown area, after dark, with the safety of the other individuals to consider. The employee was taken at her word. It was not until later when one of the other individuals came forth and reported something different. The Agency's management, upon hearing a different version of the accident, informed the incident manager and took the steps to place the employee on administrative leave. However, the employee never returned to work after the new version of the accident surfaced. Disciplinary actions would not have occurred until the internal investigation was completed. The investigation was completed and reviewed on 2/05/08 and the employee was terminated effective 2/06/08. Disciplinary action was recommended and swift action was taken.	2/06/08 2/19/08

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I 500	Continued From page 4 b. On February 8, 2008, review of the facility's transportation policy revealed that any staff who uses a facility vehicle for transporting clients in the community must complete a 'Transportation Log' entry on the date of use. On February 8, 2008, interviews with shift supervisors revealed that the direct staff driver had failed to complete a transportation log on January 19, 2008. The facility's internal investigation report did not address this subject and as noted above, the direct staff driver worked in the facility on Sunday, January 20, 2008 and again on Tuesday, January 22, 2008 without receiving any form of reprimand or disciplinary action for failing to use the transportation log. c. There was no clear evidence that the direct staff driver was carrying a working cell phone when she left the facility on January 19, 2008 to pick-up residents, as required by policy. The facility's Incident Review Committee documented a February 5, 2008 review of the incident and internal investigation. There was no evidence, however, that management had sought to determine compliance with their transportation policies.	I 500	b. The Agency is currently insuring that the program drivers complete a transportation log. c. The driver did have a working cell phone at the time of the accident. The internal investigation concluded that the employee provided a false report of the event. It is assumed by defining the report as false that the NCC transportation policy was not followed.	3/12/08